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FISCAL IMPACT STATEMENT

LS 7434
BILL NUMBER: SB 551

NOTE PREPARED: Apr 5, 2013
BILL AMENDED: April 2, 2013

SUBJECT: Federal Health Care Reform.

FIRST AUTHOR: Sen. Miller Patricia
FIRST SPONSOR: Rep. Clere

BILL STATUS: CR Adopted - 2nd House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: (Amended) This bill provides for implementation of the federal Patient Protection and Affordable Care Act (ACA) with respect to a health insurance exchange (HIX) in Indiana. It specifies requirements for health plans issued through a HIX including application of Indiana insurance law.

The bill requires certification of navigators and registration of application organizations related to a HIX.

The bill provides for dissolution of the Indiana Comprehensive Health Insurance Association (ICHIA).

The bill extends the deadline for the Family and Social Services Administration (FSSA) to apply for a Medicaid State Plan amendment for family planning services and supplies as allowed by the ACA.

The bill defines populations that may be subject to Medicaid resource requirements. The bill also specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost sharing amounts. It also eliminates certain Medicaid eligibility resource requirements.

The bill specifies that Medicaid services include pharmacist services. It also adds Medicaid rehabilitation option services, chiropractic services, and optometric services to the Healthy Indiana Plan (HIP).

The bill requires the Office of Medicaid Policy and Planning (OMPP) to negotiate with the United States Department of Health and Human Services (U.S. DHHS) for a Medicaid State Plan amendment or Medicaid waiver concerning expansion of Medicaid. The bill further requires the Office of the Secretary of Family and Social Services (FSSA) to report to the State Budget Committee and the Health Finance Commission if

negotiations are unsuccessful.

The bill also requires the OMPP to apply to U.S. DHHS to amend the state Medicaid plan to require Medicaid recipient cost sharing.

The bill requires the OMPP to present specified information to the Health Finance Commission (Commission) before August 1, 2013. It requires certain state agencies to report to the Commission concerning a HIX in Indiana. The bill also requires the OMPP to report to the Commission and the Select Joint Commission on Medicaid Oversight (SJCMO) concerning specified information regarding the participation of the aged, blind, and disabled Medicaid population in risk-based managed care, managed fee-for-service programs, and home and community-based services management programs.

The bill establishes the Indiana Affordable Care Committee.

Effective Date: Upon passage; July 1, 2013.

Summary of NET State Impact: *Summary:* Certain provisions in the bill are required to be done to comply with the implementation of the ACA. The resources necessary to accomplish these provisions are assumed to be included in the budget requests of the affected agencies or the Medicaid forecast for the biennium.

The dissolution of ICHIA would result in savings of approximately $10.6 M in FY 2014 and $48.85 M in FY 2015 if the current appropriation level is considered to be the baseline budget. The establishment of regulations concerning Navigators and assisters is intended to be self-funding. Other provisions depend on negotiations with the federal government and are indeterminate.

Medicaid Resource Standard Revision: The bill provides that, excluding the aged, blind, and disabled population, most Medicaid eligibility categories applicable to applicants between ages 19 to 65 will have no resource test applied to determine Medicaid eligibility as required under the ACA. The fiscal impact of this provision if any, should be a factor in the "woodwork effect" projections included in the September 18, 2012, "Milliman Medicaid Financial Impact Analysis" and should therefore be included in the December Medicaid forecast.

(Revised) *Elimination of the Section 209(b) Status/Conversion to 1634 Status:* The bill specifies that the aged, blind, and disabled population will be subject to asset limitations established by the federal Supplemental Security Income program and to an income limitation of 100% federal poverty level (FPL). The bill also specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost-sharing amounts. These provisions are linked to the conversion of the state to 1634 disability determination status that is included as an assumption used to develop the December Medicaid forecast. The net fiscal impact of the provisions is estimated to be $23 M in state savings.

(Revised) *Authority to Negotiate a Medicaid Expansion:* The fiscal impact of this provision depends on actions required to be taken by the FSSA and the response of the federal government. The Medicaid fiscal impact could range between $0 to the estimated biennium state cost of $173.2 M for the Medicaid expansion population under the provisions of the federal Affordable Care Act.

The bill provides enabling language to allow the Department of Insurance (DOI) and the Family and Social

Services Administration (FSSA) to adopt rules, to contract with, and to share data with a health insurance exchange (HIX). These provisions are required as a result of the implementation of the ACA.

The bill also requires the establishment of a course of study, an examination, and certification and registration procedures for persons or application organizations intending to act as navigators or application organizations with regard to the HIX required under the ACA. This provision is required to be supported by the fees assessed on applicants.

(Revised) *Chiropractic Benefit Under HIP:* The fiscal impact of the provision to include chiropractic services as a required HIP benefit is dependent on how the ACA would be implemented with regard to the use of the HIP benefit model after January 1, 2014. Originally scheduled to expire on December 31, 2012, the HIP is operating under a one-year waiver extension granted by the federal Centers for Medicare and Medicaid Services (CMS). The provision would have only associated administrative costs if the HIP is discontinued as of January 1, 2014, since the provisions in the bill would be effective for six months - about the period of time it takes to complete the processing of a waiver amendment through CMS. If the HIP waiver is extended, the federal fiscal neutrality requirements would remain a factor with regard to the provision of chiropractic services. If the HIP model is allowed to be used for an expansion of Medicaid eligibility, chiropractic services would be required to be provided to the expansion population. An estimate for the cost of the inclusion of chiropractic services is not available at this time.

(Revised) *Medicaid Rehabilitation Option Services as a Benefit Under HIP:* The bill would specify that the HIP mental health care service benefit must include Medicaid Rehabilitation Option (MRO) services for qualifying individuals. The meaning of this provision is unclear since the MRO is a financing mechanism for mental health services provided to Medicaid eligibles by community mental health centers - not a defined benefit. The fiscal impact if any, would be dependent on the use of the HIP benefit model after January 1, 2014.

(Revised) *Optometric Services as a Benefit Under HIP:* FSSA reports that optometric services are currently provided as a benefit within the HIP.

(Revised) *Pharmacist Services as a Required Medicaid State Plan Benefit:* The bill would add pharmacist services to the list of services provided in the state Medicaid program. The fiscal impact would depend on how the OMPP would define allowable pharmacist services to be reimbursed, the reimbursement amounts, and how the inclusion of the defined services might impact the structure of the existing pharmacy dispensing fee model.

The extension of the deadline for the application of the Medicaid State Plan amendment for family planning services has no fiscal impact since the State Plan amendment has been approved and the eligibility and services were made available to recipients effective January 1, 2013.

The Health Finance Commission reporting requirements should be accomplished within the current levels of resources available to FSSA, DOI, and the ISDH.

Explanation of State Expenditures: (Revised) *Authority to Negotiate a Medicaid Expansion Under ACA:* Any fiscal impact of this provision would depend on the outcome of the authorized negotiations. The bill requires the Secretary of FSSA to negotiate for a Medicaid State Plan amendment or waiver necessary to implement a program providing coverage for individuals between the ages of 19 and 64 who have an annual household income of 133% of the federal poverty level or below. (Because of required income disregards, the effective income level is 138% FPL.) The bill specifies certain components of the HIP program that must be

included in a State Plan amendment or waiver for the expansion and specifies that any expansion must include a provision allowing for automatic termination of the expansion if federal financial participation rates are reduced from the levels specified in the ACA as of January 1, 2013. The bill further authorizes the Secretary of FSSA to use any health care service model or health care service third-party payment model in providing for the expansion population. This provision appears to nullify the use of the specified program components of the HIP program previously mentioned. The bill further specifies that the FSSA may not implement a State Plan amendment or waiver expanding Medicaid until a sustainable financing plan has been developed and reviewed by the State Budget Committee. If the Secretary is not successful in negotiating an expansion program meeting the requirements of the bill, the Secretary is required to report the reasons that an agreement could not be reached to the Health Finance Commission and the State Budget Committee. Should the U.S. DHHS approve the State Plan amendment, the estimated fiscal impact would be as discussed below.

(Revised) *Medicaid Expansion to 133% FPL.* This analysis is based on the September 18, 2012, "ACA - Medicaid Financial Impact Analysis" prepared by Milliman, the state's contracted Medicaid actuary. It is assumed that ACA-required expenses unrelated to any expansion of eligibility as projected by Milliman (Scenario 1) are included in the Medicaid forecasted expenditures for the purposes of the budget. It is further assumed that the cost of the full expansion will be the scenario using the Milliman projected participation rates (Scenario 3), since the analysis specifically states that it should not be expected that the full participation projected in Scenario 4 will occur. The incremental cost to the state of an expansion of Medicaid eligibility on January 1, 2014, to 133% of FPL was estimated by Milliman as shown below.

Expansion to 133% FPL	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Incremental State Dollars	$ 66.6 M	$ 106.6 M	$ 103.8 M	$ 175.2 M
Incremental Federal Dollars	$ 1,286.3 M	$ 2,666.7 M	$ 2,792.2 M	$ 2,856.7 M
Total Incremental Expenditures	$ 1,352.9 M	$ 2,773.3 M	$ 2,896.7 M	$ 3,031.9 M

Medicaid is jointly funded by the state and federal governments. The effective state share of program expenditures is approximately 33% for most current services. Current Medicaid medical services are matched by the effective federal match rate (FMAP) in Indiana at approximately 67%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%. Under provisions of the ACA, the enhanced FMAP for the newly eligible population will be:

(1) 100% for CY 2014, 2015, and 2016;
(2) 95% in CY 2017;
(3) 94% in CY 2018;
(4) 93% in CY 2019; and
(5) 90% in CY 2020 and thereafter.

The Milliman enrollment analysis for FY 2015, projects the total Medicaid/CHIP population to be 1,205,000 with no expansion. Expansion to 133% FPL is estimated to provide coverage to an additional 427,000 individuals for a total enrollment of 1,632,000.

The longer a state waits to expand Medicaid eligibility to 133% FPL, the more expensive it will become to implement after CY 2016. The U.S. DHHS has specified that the ACA enhanced FMAP for expansion populations is only available in the circumstance of a full expansion; partially expanding the Medicaid-eligible

population to a lower FPL income standard would qualify only for the state's normal FMAP percentage.

(Revised) *Department of Corrections (DOC) and FSSA Expenditures:* The fiscal impact of a Medicaid expansion on DOC and FSSA medical expenditures would be expected to produce some level of savings. However, there are no data available at this time regarding the extent of acute inpatient care paid for residents of state facilities. The State Budget Agency currently administers an annual General Fund appropriation of $25 M specifically for payment for medically necessary services provided outside the institutions. The extent to which these services include inpatient services would determine the potential level of savings available. Initial savings may be offset by administrative expenses necessary for OMPP to implement a program and coordinate with the affected agencies.

Medicaid Cost-Sharing State Plan Amendment: The bill requires the FSSA to amend the State Plan to require Medicaid recipients to participate in cost sharing as allowable under federal law. Certain Medicaid recipients may already to be subject to cost sharing since a limited amount of cost sharing is allowable under federal law. The ACA allows states to design alternate benefit packages within specified parameters for defined populations. Proposed federal rules have been drafted that allow for higher cost sharing for individuals with incomes above 100% of FPL. However, without a specific proposal, the fiscal impact if any, of this provision is indeterminate.

Revision of the Medicaid Resource Standard: In accordance with provisions of the ACA, the bill eliminates provisions allowing resource standards for pregnant women, children, and other specified populations. The bill specifies that resource standards may be applied to recipients and applicants that are aged, blind, or disabled, SSI-eligible, a person meeting level-of-care requirements and applying for long-term care services, or an individual applying for Medicare cost-sharing assistance. Most other eligibility categories between ages 19 and 65 will have no resource test applied. This provision of the ACA is intended to streamline the Medicaid application and eligibility determination process and is based on the assumption that the majority of low-income persons who earn less than the income eligibility standards do not have assets that would enable them to pay for health care. The fiscal impact of this provision if any, should be included in the September 18, 2012, "Milliman Medicaid Financial Impact Analysis" as part of the "woodwork effect" and should therefore also be included in the December Medicaid forecast.

(Revised) *Elimination of the Section 209(b) Status/Conversion to 1634 Status:* The bill specifies that the aged, blind, and disabled population will be subject to asset limitations established by the federal Supplemental Security Income program. This provision would allow for the elimination of the separate disability determination process and the associated expenses as well as the spend-down program. The bill would specify that the qualifying income level for the aged, blind, and disabled population would be 100% of the FPL.

(Revised) *Medicare Savings Program:* The bill also specifies low-income Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost-sharing amounts. These provisions are linked to the conversion of the state to 1634 disability determination status that is included as an assumption used to develop the December Medicaid forecast. The net fiscal impact of the provisions related to the conversion of the Medicaid program to the 1634 status is estimated to be $23 M in state savings.

Oversight of Insurance Offered on the HIX: The bill specifies the Department of Insurance would provide oversight of insurance products provided through the HIX and that all requirements of the DOI apply to health plans offered on the exchange. The ACA specifies that all insurance offered on the HIX must meet state insurance requirements as well as federal provisions. The bill also allows the DOI to enter into contracts with

a HIX for the performance of necessary functions and to share information necessary to implement the HIX. The workload of the DOI will increase with the implementation of the federally facilitated exchange as a requirement of the ACA.

Registration of Application Organizations and Certification of Navigators: The bill also requires that individuals or application organizations intending to act as navigators in Indiana under the provisions of the ACA must meet state certification and registration requirements for HIX navigators and application organizations. (Federal rules implementing the HIX specify that in order to receive a Navigator grant, individuals or entities must meet any licensing, certification, or other standard prescribed by the state or the HIX, if applicable.) The DOI, in consultation with FSSA, is required to develop a curriculum for a required course of study and an examination that will be required for the certification of navigators. The bill also requires development of continuing education requirements for ongoing certification and for a process for an insurance producer or consultant to qualify to be designated as a navigator. The development of the certification and registration program will impact the workload of the DOI; however, the DOI is required to collect fees sufficient to cover the expense of the implementation of the certification and registration program. The DOI will need to promulgate rules to establish the requirements of the navigator certifications and the application organization registration requirements. Rule-making is considered to be a core activity of agencies and should be able to be accomplished within the current level of resources available.

Dissolution of ICHIA: As a result of the ACA and its elimination of preexisting conditions exclusions, limitation of annual and lifetime caps, and the inability to reject applicants due to health conditions, the ICHIA program is no longer necessary. There will no longer be a need to operate the high-risk ICHIA program after coverage for insurance sold on the HIX becomes effective January 1, 2014. The bill requires the corporation to submit a plan of dissolution and specifies items that must be included in the plan. The DOI is responsible for approval of the dissolution plan. The termination of the ICHIA program is not a requirement of the ACA - it is no longer necessary because of the ACA.

The dissolution of ICHIA will require ICHIA participants to transition to qualified insurance products sold on the HIX. (These products are projected to cost less than the coverage offered under ICHIA.) The ICHIA General Fund appropriation for the current biennium is $97.7 M The corporation has prepared a plan for termination and transition of participants, which is included in the FY 2014 - FY2015 budget request. The ICHIA has requested $38.25 M for the upcoming biennial budget to pay the remaining projected incurred claims tail, and to discontinue other activities managed by the program. If the current appropriation level is considered to be the baseline budget, the repeal would result in savings of approximately $10.6 M in FY 2014 and $48.85 M in FY 2015. The bill also provides that any funds remaining in the ICHIA on the date of the final dissolution must be transferred to the General Fund.

Termination of ICHIA Coverage Effect on Healthy Indiana Plan (HIP): The bill would allow former ICHIA participants who no longer have coverage under ICHIA, and who otherwise meet the income eligibility and other requirements of the HIP Medicaid waiver to be eligible for the HIP benefits without going without coverage for the currently required 6-month period of time. The provision would require a waiver amendment to allow the waiving of the waiting period to be submitted to CMS and approved in order to receive the federal matching funds for this population, which is likely to be small. Further, the HIP program waiver would have to be extended or renewed in order to be of use to former ICHIA participants since it expires December 31, 2013.

(Revised) *Reporting Requirements:* The bill requires the OMPP to present to the General Assembly and the

Health Finance Commission a plan concerning a requirement for risk-based managed care for individuals enrolled in an aged, blind, or disabled eligibility category of the Medicaid program and how health care should be provided for current Healthy Indiana Plan members and individuals that are dually eligible for Medicaid and Medicare. The OMPP is also to provide information regarding the number of participants in the two programs who would be eligible for a tax credit under the provisions of the ACA. The OMPP should be capable of complying with this requirement within the current level of appropriations available to the agency.

(Revised) *Affordable Care Study Committee:* The bill establishes the 17-member Affordable Care Study Committee consisting of 8 legislators, 6 lay members, and 3 state employees. The committee is to operate under the policies governing study committees adopted by the Legislative Council. Legislative Council resolutions in the past have established budgets for interim study committees in the amount of $16,500 per interim for committees with more than 16 members. The committee would be staffed by the Legislative Services Agency. The committee is to study and make recommendations concerning the establishment of a HIX in Indiana, and the definition of Essential Health Benefits for use in the state. The committee is also to receive and consider annual reports from FSSA concerning the status and operation of the HIX established for Indiana.

(Revised) *Expanded Benefits Under HIP:* The bill would add chiropractic services to the list of benefits required to be included by the HIP in a manner and to the extent as those offered for physician office services. OMPP reported to the Health Finance Commission during the 2008 interim session that chiropractic services were not offered in the HIP benefit package due to federal fiscal neutrality requirements for the HIP Medicaid waiver. The fiscal impact of the requirement would depend on how the benefit is structured within the waiver and how long the waiver would continue to operate. In 2010, the OMPP actuary estimated a range of additional annual cost to the HIP of $1.1 M to $2.6 M, depending on the limits placed on the chiropractic benefit. However, since the bill requires that chiropractic services must be offered in the manner and to the extent as those offered for physician office services, the higher end of the estimated cost range ($2.6 M) could be the annual cost of adding this benefit.

(Revised) The bill also adds optometric services to the list of benefits required to be included in the HIP. The OMPP reports that optometric services are currently covered in the HIP program and that adding this provision would have no fiscal impact. (Optometric services only are covered by the HIP; eyeglasses and other products are not covered.)

Additional Information: Premium Assistance Tax Credits : Dually eligible individuals would not be eligible for premium assistance tax credits nor would any HIP participant below 100% FPL. At the end of September 2012, there were 41,064 enrolled participants in the HIP program, 70% of whom, or 28,736, had income levels at or below 100% of the FPL and therefore would not be eligible for premium assistance. (The premium assistance amount is not available for any coverage month that an individual is eligible for minimum essential coverage outside the individual issue market. Minimum essential coverage is health insurance coverage under Medicare, Medicaid, the Children's Health Insurance Program (CHIP), military service and Peace Corps-related coverage, an employer-sponsored plan, or a grandfathered plan.) Additionally, the tax credits can only be obtained by qualifying individuals who file federal tax returns.

2013 Federal Poverty Guidelines						
# in Family/ Household	**100% FPL**	**138% FPL**	**150% FPL**	**200% FPL**	**300% FPL**	**400% FPL**
1	11,490	15,856	17,235	22,980	34,470	45,960
2	15,510	21,404	23,265	31,020	46,530	62,040
3	19,530	26,951	29,295	39,060	58,590	78,120
4	23,550	32,499	35,325	47,100	70650	94,200
5	27,550	38,019	41,325	55,100	82,650	110,200
6	31,590	43,594	47,385	63,180	94,770	126,360

(Revised) *Newly Eligible Expansion Population - Benchmark Benefits:* Individuals who are included in the newly eligible group for Medicaid are entitled to benchmark benefits or benchmark-equivalent coverage rather than full Medicaid benefits. (Federal matching funds are not available for traditional Medicaid benefits for this group.) The minimum coverage requirements for benchmark-equivalent plans are inpatient and outpatient hospital services; physician and surgical services; laboratory and x-ray services, well-baby and well-child care, and other preventive services; prescription drugs; and mental health services.

(Revised) *Expansion Populations - DOC and FSSA:* Currently, the Medicaid Act provides an exception to the inmate prohibition for federal matching funds when a resident or inmate becomes an inpatient in a medical institution. CMS has clarified that federal matching funds would be available when a resident or inmate is admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or ICF-MR, provided that they meet any additional criteria for the services such as income eligibility or level-of-care requirements for long-term care. Current Indiana Medicaid eligibility is not available generally to nondisabled adults without dependent children. If Indiana Medicaid would be expanded under the Affordable Care Act to include adults under the age of 65 with income below 138% of the federal poverty level, this exception might provide for the possibility to realize increased savings on medical expenses incurred for residents of state-run institutions and inmates of correctional facilities. The inmate exception could also result in some savings with regard to inmates or residents who are currently eligible for Medicaid and require inpatient services. An example would be inpatient labor and delivery services for pregnant women. The level of savings available would depend on the extent of services currently provided that could qualify for Medicaid federal financial participation and the expansion

(Revised) *Medicaid Expansion:* The Milliman analysis excluded the college and graduate student population because the data indicated they may not have been appropriately grouped with their parents, causing an inappropriate match between income level and insurance coverage. The exclusion of this group may cause the expansion costs to move towards the maximum exposure cost range included in the analysis. Connecticut, a state that chose to expand the low-income population early, found that families have dropped insurance coverage for their college students when they determined they could be covered at no cost under Medicaid. Connecticut has requested a waiver from CMS that would allow students claimed as dependents for purposes of a parent's income tax liability be excluded from Medicaid coverage.

(Revised) *Risk-Based Managed Care:* The Medicaid managed care programs (Hoosier Healthwise, Healthy Indiana Plan (HIP), and Select Care) operate under federally approved waivers. The regulation waived is the recipient's freedom of choice. Managed care organization's (MCO) recipients select or are assigned a primary

care provider to give the individual a "medical care home". The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of services, such as emergency department services, is one of the methods that MCOs use to control costs within the network. The state pays a predetermined capitated amount for each MCO member per month regardless of the cost incurred by the MCO for the member's care.

Explanation of State Revenues: The DOI is required to collect from navigator and assister applicants for certification, registration, and renewal fees sufficient to cover the costs of implementing a prescribed course of study, an examination, and continuing education requirements. [See *Explanation of State Expenditures* above.]

(Revised) *Medicaid Expansion to 133% FPL.* [See *Explanation of State Expenditures* for the discussion of federal Medicaid matching funds.]

Explanation of Local Expenditures: (Revised) *Medicaid Expansion to 133% FPL and Township Trustees:* Expansion of Medicaid to the low-income adult population could result in savings to townships and counties by virtue of providing Medicaid coverage for the adult population that would be newly eligible for coverage. In CY 2011, township trustees provided just over $1 M in healthcare expenditures from township sources. There are no data to indicate whether expenditures were for services or products that would have been covered by Medicaid or if the individuals on behalf of whom expenditures were made would have been eligible for Medicaid under the required ACA expansion.

Explanation of Local Revenues:

State Agencies Affected: DOI; ICHIA; FSSA; DOC; ISDH; LSA.

Local Agencies Affected: Township trustees.

Information Sources: Douglas Stratton, ICHIA Executive Director; Logan Harrison, DOI; Seema Verma, Indiana State Health Care Reform Lead, FSSA; "General Guidance on Federally-Facilitated Exchanges", Center for Consumer Information and Insurance Oversight, CMS; Federal Register/Vol. 77, No. 59, March 27, 2012, Section 155.210 and Section 155.220. “ACA - Medicaid Financial Impact Analysis”,Milliman, September 18, 2012;”Township Assistance Report, 2011", DLGF Data Base; Wall Street Journal, July 1, 2012, “ Connecticut Seeks to Tighten Medicaid Eligibility”; CCH’s Law, Explanation and Analysis of the Patient Protection and Affordable Care Act, Including Reconciliation Act Impact, Volume 1, Wolters Kluwer, CCH, Aspen Publishers.

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